Form B2

EMERGENCY HEALTH CARE PLAN

ALLERGY TO: _____

Child's Name: _____ DOB: _____

Child Care Provider_____

History of Asthma □ Yes (high risk for severe reaction) □ No

Signs of an allergic reaction include:

Systems	**Symptoms**
MOUTH	Itching & swelling of lips, tongue, or mouth
***THROAT**	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
SKIN	Hives, itchy rash, and/or swelling about the face or extremities
GUT	Nausea, abdominal cramps, vomiting and/or diarrhea
***LUNG**	Shortness of breath, repetitive coughing, and/or wheezing
***HEART**	Weak, irregular pulse, "passing-out"

The severity of symptoms can quickly change.
***All of the symptoms listed above can potentially progress to a life-threatening situation.**

ACTION:
If ingestion or insect sting is seen or suspected:
(Prescriber should number in order all appropriate actions)

_____ Observe child for severe symptoms
_____ Administer EpiPen® or Auvi-Q® before symptoms occur
_____ Administer EpiPen® or Auvi-Q® if symptoms occur
_____ Administer Benadryl® (dose)_____ or Atarax® (dose) _____
_____ Call 911 (and request a paramedic) and transport to ER if symptoms occur
_____ Call 911 (and request a paramedic) and transport to ER if EpiPen® or Auvi-Q given

Nearest hospital: _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911
EVEN IF PARENTS OR PRESCRIBER CANNOT BE REACHED

_____ _____ _____ _____
Parent Signature Date Prescriber Signature MD/APRN/PA Date

_____ _____
Address Phone

EMERGENCY CONTACTS	**TRAINED STAFF MEMBERS**
1. _____ Relation: _____ Phone _____	1. _____ Room_____
2. _____ Relation: _____ Phone _____	2. _____ Room _____
3. _____ Relation: _____ Phone _____	3. _____ Room _____ 4. _____ Room _____

For children with multiple allergies, use one form for each allergen